CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

DEFINITION OF PERSONAL CARE SERVICES

Personal care services are defined as long-term maintenance or support services which are necessary to enable the individual to remain at or return home rather than enter a nursing facility or hospital for a condition of AIDS/HIV+ and symptomatic. Personal care services provide eligible individuals with personal care aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and/or providing household services essential to health in the home. Specifically, personal care services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes. Personal/respite care services can not be offered to individuals who are residents of nursing facilities, homes for adults, or adult foster homes licensed by the Department of Social Services.

DEFINITION OF RESPITE CARE SERVICES

Respite care is defined as services specifically designed to provide a temporary but periodic or routine relief to the **primary caregiver** of an individual who is incapacitated or dependent due to frailty or physical disability. To receive services through this Program, the following criteria must be met:

- A primary caregiver who lives in the home and who requires temporary relief from the stress of continual caregiving;
- An incapacitated or dependent individual who requires continuous and long-term care due to advanced age or physical disability;
- In-home services which are designed to relieve the physical and emotional burdens of the caregiver and only secondarily the needs of the care receiver; and
- The prevention of individual and/or family breakdown and the consequent institutionalization which may result from the physical burden and emotional stress of providing continuous support and care to a dependent individual.

This definition distinguishes between respite care and the other services in the continuum of long-term care. The four concepts listed above focus on the need of the caregiver for temporary relief. This **focus on the caregiver** differentiates respite care from programs which focus on the dependent or disabled care receiver.

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DMAS will only reimburse for services defined as personal/respite care services. Personal/respite care services to be provided by personal/respite care aides are **limited** to the following:

- Assisting with care of the teeth and mouth;
- Assisting with grooming (this would include care of the hair, shaving, and the ordinary care of the nails);
- Assisting with bathing of the individual in bed, in the tub, the shower, or a sponge bath. Routine maintenance and care of external condom catheters is considered part of the bathing process. This care applies only to external and not in-dwelling catheters, i.e., Foley catheters;
- Providing routine skin care, such as applying lotion to dry skin; not to include topical medications and/or any type of product with an "active ingredient";
- Assisting the individual with dressing and undressing;
- Assisting the individual to turn and change position, transfer, and ambulate;
- Assisting the individual to move on and off of the bedpan, commode, or toilet;
- Assisting the individual with eating or feeding;
- Assisting the individual with self-administered medications and assuring that the individual receives medications at prescribed times not to include pouring or, in any way, determining the dosage of medication;
- Supervision (the monitoring of those individuals who require the physical presence of the aide to insure their safety during times when no other support system is available or willing to provide care) - The inclusion of time in the recipient's Plan of Care solely to allow for the supervision of that recipient is appropriate when the recipient either cannot be left alone at any time due to mental or severe physical incapacitation or cannot be left alone for specified periods when assistance is not otherwise available. Individuals who cannot be left alone **at any time** are typically those who are confused all of the time and therefore likely to wander or be a danger to themselves if unsupervised. Individuals who cannot be left alone **for specified periods** are typically those who are bed-confined and either cannot call for assistance or do not have nearby support to assist, and the period during which they are without support presents a risk to their physical health (e.g., the individual is incontinent and bed-bound,

alert and oriented but, because the primary care giver must be outside of the home for half a day, has no one during that period who can come in to change her and prevent skin breakdown). In this example, a split shift service may provide her with the additional care during the period needed without adding supervision, or depending on the circumstances, the individual may need additional time in the Plan of Care for supervision time.

Supervision cannot be considered necessary because the recipient's family or provider is generally concerned about leaving the recipient alone for long periods of time or would prefer to have someone with the recipient. There must be a clear and present danger to the recipient as a result of being left unsupervised. Supervision cannot be authorized for persons whose only need for supervision is for assistance exiting the home in the event of an emergency.

If the nurse supervisor determines that the recipient needs supervision added to the Plan of Care, the nurse supervisor must document on the Supervision Request Form the individual's condition that requires supervision in order to be safely maintained at home. This form must be submitted to the DMAS analyst for approval whenever the amount of supervision time makes the total number of hours on the Plan of Care exceed the amount allowed for the recipient's level of care. A copy of this form is in Appendix C.

Supervision involves the physical presence of another person in the home for a set period of time when a family member or other support person is not available to care for the recipient. Usually, this means that the family member or other support person is not in the home during that time, but not necessarily. A person may be in the home but not be available to supervise the recipient because of other responsibilities (e.g., the caregiver provides care to other persons which prevents his or her ability to care for the recipient or the caregiver has an office in or works out of his or her home).

The amount of supervision time included in the Plan of Care must be no more than is necessary to prevent the physical deterioration or injury to the recipient. In no event may the amount of time relegated solely to supervision on the Plan of Care exceed eight hours;

- Administration of bowel and bladder programs by the aide under special training and supervision. The personal/respite care aide (PCA) may be authorized to administer physician-ordered bowel and bladder programs to individuals who do not have any other support available. This authorization could only be given if the provider agency has documented that the aide has received special training in bowel and bladder program management, has knowledge of the circumstances

that require immediate reporting to the nurse supervisor, and the nurse supervisor has observed the aide performing this function.

The Screening Committee may not include this service on the Plan of Care prior to contacting the agency chosen to provide the service to assure an aide with adequate training is available. The nurse supervisor has the responsibility to identify and assess those individuals thought to be appropriate for safe bowel and bladder management by the personal care aide.

Certain conditions exist that would contraindicate having the aide perform a bowel program, i.e., patients prone to dysreflexia such as high level quadriplegics, head and spinal cord injured patients, and some stroke patients. The bowel program may include, if necessary, a laxative, enemas or suppositories to stimulate defecation.

However, the laxative cannot be "administered" by the PCA, even through part of the bowel program (suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel program). Replacement of a colostomy bag as part of the bath is included. Digital stimulation and removal of feces within the rectal vault may be a necessary part of the bowel maintenance or training program. However, removal of impacted material is not permitted. (None of the procedures included here may be administered except as part of a physician-ordered bowel program.)

The bladder program may not include any invasive procedures such as catheterization, instillations or irrigations, but can include bladder training activities. Bladder retraining is limited to time management of urination without any invasive procedures or voiding stimulation. The nurse supervisor must be available to the aide and be able to respond to any complications immediately;

- Administration of range of motion exercises by the aide when instructed and supervised by the nurse supervisor. Range of motion exercises ordered by the physician may be performed by the aide when the aide has been instructed by the nurse supervisor in the administration of maintenance of range of motion exercises, and the aide's correct performance of these exercises has been witnessed and documented by the nurse supervisor. This does not include strengthening exercises or exercises aimed at retraining muscle groups, but includes only those exercises used to maintain current range of movement without encountering resistance;

- Routine wound care by the aide which does not include sterile technique. The aide can perform routine wound care which does not include sterile treatment or sterile dressings. This would include care of a routine decubitus, defined

as a decubitus which is superficial or does not exceed stage 2 (sore penetrates to the underlying subcutaneous fat layer, shows redness, edema, and induration, at times with epidermal blistering or desquamation). Normal wound care would include flushing with normal saline solution, washing the area, drying the area, and applying dry dressings as instructed by the nurse supervisor. This does not include the application of any creams, ointments, sprays, powders, or occlusive dressings;

- Checking the temperature, pulse, respiration, and blood pressure and recording and reporting as required; and

- Home Maintenance Activities - These activities which are related to the maintenance of the home or preparation of meals should only be included on the Plan of Care for individuals who do not have someone available (either living in the home or routinely coming in to provide assistance). Individuals living in the home with the recipient who would be expected to perform housekeeping and cooking activities for themselves should provide the recipient's home maintenance activities while completing their own. These activities are:

  - Preparing and serving meals, not to include menu planning for special diets;
  - Washing dishes and cleaning the kitchen;
  - Making the bed and changing linens;
  - Cleaning the individual's bedroom, bathroom, and rooms used primarily by the personal care recipient;
  - Listing for purchase supplies needed by the individual;
  - Shopping for necessary supplies for the individual if no one else is available to perform the service; and
  - Washing the individual's laundry if no other family member is available or able.

Under respite care services, a Licensed Practical Nurse (LPN) can perform selected nursing procedures performed under the direction of a Registered Nurse (RN). Such selected procedures may include:

- Administration of medications;
- Care of tracheostomies, feeding tubes, etc.; and
- Wound care requiring sterile technique.

When an LPN is required, the LPN would also provide any of the services normally provided by an aide.

Services Excluded From Coverage/Reimbursement Under Personal/Respite Care

DMAS **will not reimburse** provider agencies for any services that are not listed above. These include, but are not limited to, the following activities:

Transportation

An **aide** is not allowed to transport an individual (i.e., drive a vehicle for an individual). The family and/or social support is expected to perform this service or make arrangements for alternate transportation (taxi, ambulance, etc.). The personal care aide may **accompany** the individual, however, if all of the following criteria are met:

- The individual is being transported to an essential medical appointment (doctor's appointment, outpatient services, etc.);
- The aide is essential for the safe transport of the individual to (assist in transfers, ambulation, behavior management, etc.);
- No other individual is available to accompany the individual;
- The total time required by the aide for the day, including the time required to accompany the individual, does not cause the individual's weekly authorized hours to be exceeded. If the total time required exceeds the daily hours, the additional time may be deducted from another day as long as this does not jeopardize the recipient's health and safety;
- The RN supervisor has been notified in advance of the appointment and the RN has approved and so documented and dated in the RN notes in the individual's record; and
- When the aide is required to accompany the individual based on the above criteria, DMAS will reimburse the agency for the time the aide is accompanying the individual to such medical appointments. This must be documented on the aide's record.

Skilled Services

Services requiring professional skills or invasive therapies such as tube feedings, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique, **cannot be performed by personal/respite care aides.** Routine maintenance and care of external condom catheters does not constitute a skilled service and can be performed by the aide as part of the bathing process.

Provision of Services for Other Members of the Recipient's Household Who Are Not Medicaid Personal/Respite Care Recipients

DMAS will reimburse the provider agency only for services rendered to the recipient. DMAS will not reimburse the provider agency for services rendered to or for the convenience of other members of the recipient's household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing dishes, family laundering, etc.) DMAS also will not reimburse for the provision of unauthorized services.

RELATION TO OTHER MEDICAID-FUNDED HOME CARE SERVICES

Virginia currently offers two other home-based services through the Virginia State Plan for Medical Assistance: home health and hospice care.

Home Health

The major differences between home health and personal care services are the increased involvement of professional medical personnel in home health services and the emphasis in home health on short-term, intermittent, restorative care rather than long-term maintenance functions. A home health aide shall be assigned when the responsible physician has specified in the recipient's Plan of Treatment the need for such a service. This Plan of Treatment must be re-evaluated and signed by the responsible physician not less than once every 60 days. The registered nurse shall make a supervisory visit to the recipient's residence at least every two weeks to assess relationships and determine whether goals are being met.

Personal/respite care services are defined as long-term maintenance or supportive services which are necessary to enable the individual to remain at home rather than enter a nursing facility or hospital for a condition of AIDS/HIV+ and symptomatic. Although aides may provide care to recipients requiring skilled care, they **cannot** perform any services not outlined in this chapter.

Services requiring professional skills (such as tube feedings, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique) cannot be performed by personal/respite care aides. It is permissible for a nurse to give skilled services at the same time that the aide is in attendance. Medicaid cannot be billed for a home health aide and a personal/respite care aide providing identical services to the same recipient at the same time. Identical service is defined as the services listed in the section titled "Covered Services" in this chapter.

Hospice Care

Hospice is an autonomous, centrally administered, medically directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient

and his or her family. It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during bereavement. The goal is to maintain the individual at home for as long as possible while providing the best care available to the patient, thereby avoiding institutionalization.

To be covered, hospice services must be elected by the recipient, and his or her terminal illness (prognosis of six months or less) must be certified by the recipient's attending physician and the hospice medical director. A hospice must routinely provide a core set of services which include nursing care, physician services, social work and counseling. **The personal/respite care provider must contact his or her analyst prior to initiating service for any individual who is receiving hospice services.**

Home and Community-Based Long-Term Care Services

The Department of Medical Assistance Services provides reimbursement for a variety of in-home services (personal care, adult day health care and respite care) designed to offer individuals an alternative to institutionalization. Individuals may be authorized to receive one or more of these services either solely or in combination, based on the documented need of the service(s) to avoid nursing facility placement. The Nursing Home Pre-Admission Screening Committee must give prior authorization for any Medicaid-reimbursed home and community-based care, subject to DMAS approval prior to reimbursement for any claims.

Adult Day Health Care

Adult day health care (ADHC) can be offered only to individuals who meet nursing home pre-admission screening criteria (the same long-term care criteria as required for personal care and respite care admission) and for whom ADHC (either solely or in conjunction with personal care and/or respite care) would be an appropriate alternative to institutional care.

The significant difference between ADHC and personal care is the congregate setting in which adult day health care is rendered. DMAS will contract with qualified adult day care centers licensed by the Virginia Department of Social Services and which meet all DMAS provider standards to provide ADHC services to Medicaid-eligible individuals who have been authorized to receive ADHC.

The services offered by the adult day health care program must be designed to meet the needs of the individual participant. Thus, the range of services provided by the adult day health care center to each individual may vary to some degree. There must, however, be a minimum range of services available to every Medicaid adult day health care participant: nursing services, rehabilitation services coordination, transportation, nutrition, social services, and recreation and socialization services.

Adult day health care, when offered in conjunction with personal care services, would be considered a secondary home and community-based care service necessary for the individual's continued maintenance in the community. ADHC can be offered as a secondary service to personal care by the Nursing Home Pre-Admission Screening Committee at the time of the initial assessment as long as the combination of services is deemed necessary to the individual's ability to remain in the community.

In those instances where the individual has been screened and authorized to receive only personal care and the need for ADHC as a secondary home and community-based care service has been identified, the personal care provider is instructed to contact the Department of Medical Assistance Services utilization review staff. The Department of Medical Assistance Services (DMAS) will conduct an assessment of the individual caregiver's need for ADHC, and if appropriate, authorize ADHC.

ADHC services may take the place of personal care services either completely or several days a week if it is determined this would meet the needs of the recipient.

If the individual has been screened and approved to receive ADHC and the need for personal care has been identified after ADHC has been initiated, the ADHC provider is instructed to contact the DMAS utilization review staff. DMAS will conduct an assessment of the need for personal care, and if appropriate, authorize personal care. ADHC would then become the secondary program.

ASSESSMENT AND AUTHORIZATION PROCEDURES FOR PERSONAL/RESPITE CARE SERVICES

Services will be offered only to individuals who have been certified eligible as an alternative to nursing facility or hospital level of care for a condition of AIDS/HIV+ and symptomatic by a Nursing Home Pre-Admission Screening Committee (NHPASC). The committee will have explored medical, social, and nursing needs of the individual, analyzed specific services the individual needs, and evaluated whether a service or combination of existing services is available to meet these needs. The Committee will have explored alternative settings and/or services to provide the required care before making the referral for personal/respite care services. A copy of the DMAS criteria for community-based care is located in Appendix D.

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who **otherwise** would have to be institutionalized. Virginia offers personal/respite care as a service option under two home and community-based care waivers: the Elderly and Disabled Waiver and the Waiver for Individuals with AIDS. Under the Elderly and Disabled Waiver, services may be furnished **only** to persons:

1. Who meet the nursing facility or pre-nursing facility criteria as outlined in Appendix D;

2. Who are financially eligible for Medicaid;

3. For whom an appropriate Plan of Care can be established;

4. Who are not residents of nursing facilities, or homes for adults and adult foster homes licensed by the Department of Social Services; and

5. Where there are no other or insufficient community resources to meet the recipients' needs.

Under the waiver for individuals with AIDS or who are HIV+ and symptomatic, personal/respite care services may be furnished only to persons:

1. Who, without the receipt of services under the waiver, will require the level of care provided in a hospital or nursing facility;

2. Who have been diagnosed by a physician as having AIDS and are experiencing medical and functional symptoms associated with AIDS or are HIV+ and symptomatic;

3. Who are not residents of hospitals, nursing care facilities, or homes for adults and adult foster homes licensed by the Department of Social Services;

4. Who have dependencies in some areas of ADLs and for whom an appropriate Plan of Care can be developed which is expected to avoid more costly institutional services and ensure the individual's safety and welfare in the home and community;

5. Who are financially eligible for Medicaid; and,

6. Who have no other, or insufficient, community resources available to meet their needs.

To ensure that Virginia's waiver programs are offered **only** to individuals who would otherwise be placed in an institution, personal/respite care services **can be considered only for individuals who are seeking nursing facility admission (or hospital admission for a condition of AIDS or HIV+ and symptomatic) or for individuals who are determined to be at risk of nursing facility admission (or hospital admission for a condition of AIDS or HIV+ and symptomatic) if community-based services are not offered.** Personal care/respite services must be the critical service that enables the individual to remain at home rather than being placed in an institution.

The recipient's status as a recipient in need of personal/respite care services is determined by the Nursing Home Pre-Admission Screening Committee. For individuals with AIDS, AIDS Service Organizations also contract with DMAS to perform pre-admission screening, as well as local and acute care Screening Committees. A request for a pre-admission screening for nursing facility placement can be initiated by the

individual who desires the requested care, a family member, physician, local health department or social services professional, or any other concerned individual in the community. The appropriate assessment instrument (DMAS-95 for elderly and disabled persons and the DMAS-113-A for persons with AIDS/HIV) must be completed in its entirety. The Nursing Home Pre-Admission Screening Authorization (DMAS-96) and the Screening Committee Plan of Care (the DMAS-97 for individuals authorized under the Elderly and Disabled Waiver or the DMAS-113B for individuals authorized under the AIDS/HIV+ and symptomatic waiver) must also be completed by the Committee and approved by the public health physician or attending physician, whichever is appropriate. Note: If the provider receives a referral that indicates the recipient has an HIV+ or AIDS diagnosis, the DMAS-96 must indicate that the individual has been authorized for AIDS Waiver services. This is essential to assure that the agency receives the higher reimbursement rate available for services provided under this waiver.

The Screening Committee Plan of Care indicates the services needed, any special needs of the recipient and environment, and the support available to provide services. The Screening Committee will note the number of days per week that care is needed but will not authorize the amount of service each day. The Screening Plan of Care also serves as written notification to the recipient of the estimated patient pay responsibility, when this information is available at the time of the screening, and documents the recipient's choice of long-term care options and choice of provider. **If personal/respite care services are authorized and there is more than one approved provider agency in the community willing and able to provide care, the individual must have the option of selecting the provider agency of his or her choice.**

The decision of the Nursing Home Pre-Admission Screening Committee, like any other administrative or service decision affecting the recipient, may be appealed to the Department of Medical Assistance Services. This decision should be appealed in writing by the recipient or his or her legally-appointed representative. All appeals must be filed within 30 days of the date of the final decision notification. Appeals should be directed to:

Director, Division of Client Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

PATIENTS WITH COMMUNICABLE DISEASES - AIDS/HIV+ WAIVER SERVICES

Current information regarding the transmission of Acquired Immune Deficiency Syndrome (AIDS) and other similar communicable diseases indicates that these diseases are not transmitted through casual contact, and isolation techniques or procedures are not required for providing care to individuals in their homes.

However, certain routine hygienic precautions, designed to prevent the spread of all communicable diseases, including bloodborne infections, should be taken by personal/respite care aides when rendering care to any individual, regardless of his or her known medical illness. These precautions should include care in handling sharp objects such as needles, the wearing of disposable gloves when one could become exposed to blood or other body fluids, and scrupulous hand washing before and after caring for each individual.

Personal/respite care providers are prohibited from discriminating against individuals who have been diagnosed as having AIDS and other communicable diseases. Virginia offers a range of home and community-based care services, which include personal/respite care, through an approved waiver for individuals with AIDS/HIV+ and symptomatic. Nursing Home Pre-Admission Screening Committees and certain AIDS Service Organizations and HIV Outpatient Clinics contracted with DMAS to perform screening assessments for the AIDS/HIV Waiver, are responsible for completion of assessments and authorization of services through the AIDS/HIV Waiver. The determination of the appropriateness and authorization for personal/respite care services will **not** be made solely on diagnosis. Pre-Admission Screening Committees will consider the appropriateness of the service based upon the stage of the disease process and the capability of the provider agency to adequately staff the recipient's care.

AUTHORIZATION FOR MEDICAID PAYMENT OF PERSONAL/RESPITE CARE SERVICES

There are two distinct waiver populations for which pre-admission screening is the assessment and authorization mechanism for Medicaid-funded home and community-based care services: Individuals with AIDS or individuals who are HIV positive and symptomatic and Elderly and Disabled Individuals who would otherwise require nursing facility care. Personal/respite care services for these two populations are identical in all aspects of service delivery. The authorization process is different for these waiver populations in that a different assessment and Plan of Care is used by the Screening Committee for the AIDS/HIV population (DMAS-113A and DMAS-113-B) than that for the elderly and disabled population (DMAS-95 and DMAS-97).

Screening and preauthorization of personal/respite care services by the Nursing Home Pre-Admission Screening Committee is mandatory before Medicaid will assume payment responsibility for personal/respite care services.

Medicaid will not pay for any personal/respite care services delivered prior to the authorization date of the physician's signature on the DMAS-96 approved by the Pre-Admission Screening Committee. The date of this authorization cannot be made prior to the date on which the assessment is completed and the Screening Committee makes a decision.

Medicaid will assume payment responsibility for personal/respite care services only after the Department of Social Services has determined that the individual is financially eligible for medical assistance for the dates services are to be provided.

FORMS REQUIRED FOR ADMISSION TO PERSONAL/RESPITE CARE SERVICES

The Committee which is initiating a referral will call the provider first to notify him or her that the recipient has chosen his or her agency for services and to determine if the provider is able to initiate services promptly for the recipient. If the provider can accept the referral, the Committee will send the provider a complete packet required for the agency to admit the recipient to services.

If the provider agency does not receive an entire thoroughly completed packet of referral forms, as noted below, from the Pre-Admission Screening Committee, the provider agency must notify the responsible Pre-Admission Screening Committee and request the completed packet. A provider **will not** be reimbursed for services until DMAS receives the packet of information completed by the Screening Committee, along with the provider's Plan of Care showing the start of care date.

The forms which must be thoroughly completed by the Screening Committee and forwarded to the personal care agency are:

- A completed assessment instrument: DMAS-95 (Long-Term Care Information System Assessment Form) pages 1-5 or DMAS-113-A for persons authorized for the AIDS Waiver;
- The original and a copy of the Nursing Home Pre-Admission Screening Authorization (DMAS-96). The authorization must be completed for the appropriate service (i.e., personal care, respite or AIDS services) and must be signed and dated by the physician prior to the start of services; and
- The original and a copy of the Screening Committee Plan of Care (DMAS-97 or DMAS-113B for AIDS Waiver or DMAS-300 for respite care services). This form must be completed in its entirety including documentation of Freedom of Choice.

Provider agencies are responsible for reviewing the recipient's Medicaid card and/or calling the toll-free eligibility verification number (1-800-884-9730) to confirm the recipient's Medicaid eligibility status prior to the start of care. For any recipient identified in a QMB status, the provider agency should contact that recipient's eligibility worker at the local Department of Social Services prior to the start of care to receive assurance that the recipient's services will be covered.

If the provider agency loses any of the necessary forms that should be part of the Personal Care Program, the Community-Based Care Section of DMAS should be notified immediately.

Screening Committees will make personal care or respite care referrals only to agencies which have met Medicaid requirements and are enrolled under contract as a Medicaid personal care and/or respite care provider agency.

PERSONAL/RESPITE CARE AGENCY RESPONSE TO REFERRAL

The provider agency shall not begin services for which they expect Medicaid reimbursement until the admission packet is received from the Pre-Admission Screening Committee and not before the date authorized by the Pre-Admission Screening Committee on the DMAS-96.

Upon receipt of a referral and prior to the delivery of services, the registered nurse supervisor of the provider agency must make an evaluation visit to the recipient's home. During this initial home visit, the registered nurse supervisor is responsible for the following activities:

- Introduction of the aide to be assigned to the recipient. The RN may introduce the aide to the recipient during the initial visit or any time prior to the start of services (including the first day of service);

- Discussion of the recipient's needs and review of the Plan of Care developed by the Screening Committee; and

- Completion of the Provider Agency Plan of Care (DMAS-97A) and review of this Plan of Care with the recipient and/or the recipient's family and the aide to ensure that there is complete understanding of the services that will be provided. The DMAS-97A (see Appendix C) must be completed with the recipient's name, 12-digit Medicaid number, provider agency name and number, Plan of Care needs, ADL composite score, start of care date (this is the date that the personal care aide actually began providing care; this date should also be the one used on the DMAS-122), and RN signature. A copy of the current agency Plan of Care must be kept in the recipient's home. The aide should be instructed to use the agency Plan of Care (either the recipient's copy designating time increments or a copy that shows only the tasks checked) as a guide for daily service provision.

  It is appropriate for the aide to chart tasks that are not included in the recipient's Plan of Care if the recipient has a need for the task to be done. The aide should note why this task was performed and if the need for this task continues to exist. It is then the responsibility of the RN who reviews aide logs to determine whether there is a need for the task to be included on the Plan of Care on an ongoing basis and make whatever changes are appropriate.

The evaluation visit must be documented in the nurse's notes as an initial assessment. This initial assessment must document the following:

- Introduction of the aide to the recipient; if the aide is introduced at a time other than the initial visit, this must be documented in the RN notes.

- Review of the recipient's Plan of Care with the aide, recipient and/or recipient's family/primary caregiver;

- Complete assessment to include the recipient's current functioning status, medical nursing need, current medications, social support system, other community services rendered to the recipient, and the condition of the recipient's environment. When any special maintenance care (administration of bowel and bladder programs, range of motion exercises or routine wound care) is to be provided by the personal care aide, the RN supervisor must check to make sure that a physician order is present and indicate in the initial RN supervisory note what care the aide is providing, what instructions the aide has received from the RN supervisor regarding this care, and the nurse supervisor's observation of the aide's demonstration of the correct techniques involved in this care; and

- The recipient's ability to sign aide logs.

It is the provider's responsibility to determine whether the agency can adequately provide services to an individual prior to accepting a referral for services from a Nursing Home Pre-Admission Screening Committee. There may, however, be instances where the provider is unaware of a problem that will prohibit service delivery until the nurse supervisor completes the initial assessment.

RESPONSE TO INAPPROPRIATE AUTHORIZATION

The agency should not initiate services if during the initial assessment the RN determines that the recipient is not appropriate for services because of health and safety concerns, the recipient's not meeting the criteria for the program, or the inability of the agency to adequately provide staff. **The provider RN must notify the recipient, in writing, of this decision and include in detail the reason for the decision and the effective date of this action and give the recipient the Right to Reconsideration (as outlined in chapter V).** Copies of the letter must be sent to the Pre-Admission Screening Committee and the assigned analyst. The agency will send the original screening papers back to the Screening Committee. If the recipient decides to request a Reconsideration, the provider will need to submit to the assigned DMAS analyst the documentation of the supervisory visit that documents thoroughly the reason that services were not initiated to the recipient and a complete copy of the Pre-Admission Screening Admission Packet.

ADMISSION CERTIFICATION PROCESS FOR ELDERLY AND DISABLED RECIPIENTS

The provider agency is required to submit to DMAS an enrollment packet that consists of a copy of the Admission Packet (DMAS-95, DMAS-96, DMAS-97 or DMAS-300 for respite care) along with the Provider Agency Plan of Care (DMAS-97A) before the provider may bill for services rendered. The originals will be retained by the provider agency.

For episodic respite care enrollments authorized by a DMAS analyst, a copy of the analyst's authorization and respite Plan of Care must be submitted.

The admitting provider is responsible for sending an Enrollment Packet to DMAS for a recipient who has been transferred from one provider to another. This enrollment packet consists only of the Provider Agency Plan of Care (DMAS-97A) and a letter from the admitting provider which identifies the provider who transferred the case, his or her last date of service rendered, and provides the reason for any changes made by the admitting provider to the recipient's Plan of Care.

Personal/respite care recipient enrollment Packets must be sent to the following address:

Admission Certification Analyst
Community-Based Care Section
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Personal care recipient enrollment packets must be mailed to DMAS in the self-addressed envelope (DMAS-89) provided. **This envelope must only be used for recipient enrollment packets. Do not include any other correspondence or invoices in this envelope.** The admission certification analyst will be responsible for ensuring the accuracy of all forms submitted for recipient enrollment as well as ensuring that level of care criteria and appropriateness of personal/respite care services have been met. Any packet which is received which is incomplete or incorrectly submitted will be returned to the provider for correction. **Do not submit the enrollment package without a Medicaid number.** Any enrollment Plan of Care which contains hours in excess of what is allowed for that recipient's level of care category (A, B or C as shown on the bottom of the Plan of Care), must be accompanied by the analyst's authorization letter indicating approval of the hours in excess of the category of care.

Once all information is received and reviewed, the analyst will enter the authorization for the approved number of hours into the DMAS computer system and will send the provider agency confirmation of the enrollment so that the agency can bill Medicaid for services rendered. The approved number of hours entered is from the agency Plan of Care (DMAS-97A). Any incomplete enrollment packets will be returned to the provider for completion. After the enrollment analyst enters the information into the computer, the agency will receive a computer-generated letter which confirms that the recipient is enrolled to the Medicaid system for payment of personal/respite care. The agency cannot bill for services until this letter is received.

ADMISSION CERTIFICATION PROCESS FOR AIDS WAIVER RECIPIENTS

Individuals authorized to receive personal/respite care services through the AIDS Waiver will be enrolled pursuant to DMAS receipt of an admissions packet and all plans of care

related to AIDS Waiver services submitted by the AIDS Waiver case manager. The admissions packet will indicate whether the recipient has a case manager and the identity of that case manager. The personal care provider does not submit an enrollment packet to DMAS if the recipient has a case manager. Once the RN supervisor has developed the provider agency Plan of Care (DMAS-97A), a copy of this must be forwarded to the assigned case manager who is responsible for including this information in the Case Management Plan which is submitted to DMAS. If there is no assigned case manager, the provider agency submits an enrollment package as outlined in the section titled "Enrollment Procedures for Elderly and Disabled Recipients."

Special Considerations for the Monitoring of Services to AIDS Waiver Recipients

Individuals authorized to receive personal/respite care services through the AIDS Waiver will usually also receive case management services through a case management provider agency. The case manager's role is to assure that services to the AIDS Waiver recipient are coordinated and to monitor the changing needs of the AIDS Waiver recipient and direct or authorize any changes in the amount of services needed by the recipient.

The case manager assigned to the AIDS Waiver recipient will contact the provider agency once the referral for services has been forwarded by the Screening Committee indicating authorization for AIDS Waiver services. This contact will be to assure that services have been implemented according to the authorization and that the Plan of Care developed by the provider is adequate and necessary to meet the current needs of the recipient. The provider agency staff will direct all requests for changes to the Plan of Care and report any problems with the individual's maintenance in the home environment to the case manager.

The case manager is expected to contact the provider agency, at a minimum, once every 30 days, to assure that services continue to be appropriate. **The nature of the AIDS/HIV disease is such that it is imperative that the provider agency monitor closely with the aide and the recipient the need for continued care in the amount indicated on the Plan of Care and adjust this Plan of Care as necessary.** Since AIDS/HIV patients frequently have "good" and "bad" days, it is important that the agency work out with the recipient its expectation that the recipient will contact them on days on which they require no assistance. There is no need for a formal change in the Plan of Care unless the recipient's condition seems to require an ongoing change in the amount of service rendered. The personal/respite care provider is instructed to send a copy of the DMAS-97A to the case manager when the initial Agency Plan of Care is developed and every time the 97A is modified by the provider. The case manager will be responsible for sending a copy of the DMAS-97A to DMAS to assure that the correct amount of services is entered into the DMAS systems for correct payment for personal/respite care services. The provider must send a copy of any notification sent to the recipient to terminate services and a copy of the Recipient Progress Report to the case manager for any individual receiving personal care according to the procedures in this manual, instead of the copy sent to DMAS, as with an individual under the Elderly and Disabled Waiver.

PLAN OF CARE FOR PERSONAL/RESPITE CARE SERVICES

The DMAS-97A must be completed by the provider agency prior to the start of care for any recipient. The Screening Committee Plan of Care indicates to the personal/respite care provider the general needs of the recipient in eight service needs areas. The personal/respite care provider should allocate time for the four service categories (which include 19 specific personal/respite care tasks) listed on the Provider Agency Plan of Care, consistent with the specific needs of the recipient according to the functioning and medical information included in the pre-screening assessment (DMAS-95) and the RN supervisor's assessment visit, any special considerations for service provision and the support available to the recipient. Time does not need to be allocated for each of the 19 tasks on the Plan of Care; these should only be either checked or a description given, if necessary.

Each recipient is designated a level of care based on his or her composite ADL score. The composite ADL score is the sum of a rating of six ADL categories. These six categories are a composite of 10 of the functional status items on the DMAS-95 (bathing, dressing, toileting, continency of bowel, continency of bladder, transferring, mobility, wheeling, walking, and eating/feeding). The provider should assign a rating for each ADL category which best describes the recipient based on the information on the DMAS-95 and the RN's observation at the time of the initial home evaluation. The scoring is as follows:

		ADL RATING
Bathing:	Bathes without help or with Mechanical Help (MH) only	0
	Bathes w/ Human Help (HH) or w/ HH & MH	1
	Is bathed	2
Dressing:	Dresses without help or w/MH only	0
	Dresses w/ HH or w/ HH & MH	1
	Is dressed or does not dress	2
Transfers:	Transfers without help or w/MH only	0
	Transfers w/ HH or w/ HH & MH	1
	Is transferred or does not transfer	2
Ambulation:	Walks/Wheels without help or w/MH only	0
	Walks/Wheels w/ HH or HH & MH	1
	Totally Dependent for Mobility	2
Eating:	Eats without help or w/ MH only	0
	Eats W/ HH or HH & MH	1
	Is fed: spoon/tube fed, IV,etc.	2

Continency:	Continent /Incontinent < weekly/ self-care of internal/external devices	0
	Incontinent weekly or More/ Not self-care	2

Once the recipient's composite score is derived, a level of care is designated for that recipient as either Level A, B or C. The designation of a level of care is important because the level of care determines the maximum number of hours per week of personal care services that the recipient may have allocated to his or her Plan of Care. Any hours beyond the maximum for the recipient's level of care must be preauthorized by DMAS. **Any care plan submitted without approval for hours beyond the maximum for any particular level of care will only be entered into the DMAS computer system for the maximum for that level of care. Once authorization is received, the number of hours can be increased. However, the increase in hours will not be made retroactive beyond the date the approval was received.** Prior to designating the level of care, however, the provider should develop the Plan of Care as it must reflect the true needs of the recipient and not necessarily the maximum amount of service that the recipient is able to have based on his or her level of care. The provider is able to develop a Plan of Care and subsequently make changes to the Plan of Care without prior approval from DMAS as long as the recipient's amount of service does not exceed the maximum amount established for that recipient's level of care.

Reimbursement for the full amount of services included in the Plan of Care and rendered by the provider may be denied when the recipient's Plan of Care is inflated beyond the needs of the recipient. The determination that a Plan of Care is "inflated" will be based on the pattern of utilization in the geographical locality and within the agency, and on whether the analyst has previously addressed appropriate time frames with the provider staff.

Level Of Care A - The recipient scores between 0-6 on the ADL composite rating. Recipients in Level of Care A are the most functionally capable group in personal/respite care and therefore, should usually require the least amount of services (anywhere from 7.5 to 17.5 hours per week). The maximum amount of time per week that a recipient in Level A may be provided services has been established at 25 hours per week in recognition of the many individual variations found in recipients' environments and available social support. **This maximum is based on a seven-day-per-week Plan of Care** with an average daily need for ADL care of two hours/day and housekeeping of 1.5 hours per day. Although the provider may use the maximum allowed for the level of care, it is expected that recipients will not routinely require maximum amounts of care. Within the level of care, the amount of time required to perform ADL and housekeeping tasks will vary.

The following guidelines are intended to assist the provider to determine the appropriate allocations of ADL time for individuals within Level of Care A. All individuals in Level A probably require more time for housekeeping tasks since they are more likely to live alone and occupy more living area.

1. Minimal Needs - These are the least dependent recipients, often borderline in meeting the criteria for nursing facility care (ADL score 2-3). The recipient may require prompting rather than hands-on assistance, may use mechanical help more than human help with a need for stand-by assistance:

   Average time allocated for ADL's - .75 - 1 hr/day
   Average time for Housekeeping - 1 - 1.5 hr/day

2. Average Needs - These recipients have somewhat more need for hands-on help, stand-by assist and are somewhat more dependent (ADL score 3-4):

   Average time allocated for ADL's - 1 - 1.5 hr/day
   Average time for Housekeeping - 1 - 1.5 hr/day

3. Heavy Needs - These recipients will require some help in all areas of ADL care although they will usually be mobile and can probably eat without assistance (ADL score 4-6):

   Average time allocated for ADL's - 1.5 - 2 hr/day
   Average time for Housekeeping - 1 - 1.5 hr/day

Level Of Care B - The recipient scores between 7-12 on the ADL composite rating. Recipients in Level of Care B are the least functionally capable group without skilled medical/nursing needs in personal/respite care. These recipients will probably require an average of from 15 to 28 hours per week. The maximum amount of time per week that a recipient in Level B may be provided has been established at 30 hours per week in recognition of the many individual variations found in recipients' environments and available social support. **This maximum is based on a 7-day-a-week Plan of Care** and an average daily need for ADL care of 2.5 hours/day and housekeeping of 1.75 hours per day. Although the provider may use the maximum allowed for the level of care, it is expected that recipients will not routinely require maximum amounts of care. Within the level of care, the amount of time required to perform ADL and housekeeping tasks will vary.

The following guidelines are intended to assist the provider to determine the appropriate allocations of ADL time for individuals within Level of Care B. Individuals in Level B probably require somewhere between the heavy time allocated in Level A and an average amount of time for housekeeping tasks since the population in Level B will have more individuals who have a live-in caregiver and who occupy less living area.

1. Minimal Needs - These recipients may require assistance to ambulate, but are still able to perform some tasks for themselves (ADL score 7-8):

   Average time allocated for ADL's - 1.5 - 2 hr/day
   Average time for Housekeeping - 1 - 1.75 hr/day

2. Average Needs - These recipients may require an assist to transfer as well as ambulate, eat, toilet, most ADL's (ADL score 9-10):

   Average time allocated for ADL's - 2 - 2.5 hr/day
   Average time for Housekeeping - 1 - 1.75 hr/day

3. Heavy Needs - These recipients will require the maximum amount of help in all areas of ADL care. They will usually be bed-confined and therefore, may actually take less time to render services than the recipient who performs some self-care but requires assistance (ADL score 11-12):

   Average time allocated for ADL's - 1.5 - 2.5 hr/day
   Average time for Housekeeping - 1 - 1.75 hr/day

Level Of Care C - The recipient scores 9 or more on the ADL composite rating and in addition requires heavy care and has a skilled need (wound care; specialized feeding; rehabilitation for paralysis/paresis, quadriplegia/paresis, bilateral hemiplegia/paresis; multiple sclerosis). Recipients in Level of Care C are the least functionally capable group with skilled medical/nursing needs. These recipients will probably require an average of from 20 to 30 hours per week. The maximum amount of time per week that a recipient in Level C may be provided services has been established at 35 hours per week in recognition of the many individual variations found in recipients' environments and available social support. **This maximum is based on a seven-day-per-week Plan of Care** and an average daily need for ADL care of three hours per day and housekeeping of two hours per day. Although the provider may use the maximum allowed for the level of care, it is expected that recipients will not routinely require maximum amounts of care. Within the level of care, the amount of time required to perform ADL and housekeeping tasks will vary.

The following guidelines are intended to assist the provider to determine the appropriate allocations of ADL time for individuals within Level of Care C. Individuals in Level C probably require the least amount of time for housekeeping tasks since the population in Level C will usually have a live-in caregiver who will perform most housekeeping and shopping.

1. Minimal Needs - These recipients may have the maximum in-home support and less special maintenance needs. Some of the recipients in this minimum range of needs within Level C will actually be quite dependent but may be cared for quickly merely because they do not participate in their own care:

   Average time allocated for ADL's - 1.5 - 2 hr/day
   Average time for Housekeeping - 1 - 2 hr/day

2. Average Needs - These recipients will generally require more ADL time to prevent skin breakdown by frequent turning, may require wound care, feedings completed by the family, etc., and have only moderate support to assist with this care:

   Average time allocated for ADL's - 2 - 3 hr/day
   Average time for Housekeeping - 1 - 2 hr/day

3. Heavy Needs - These recipients may be new quadriplegics, have a degenerative disease and generally will be the most difficult recipients to maintain in their homes due to their many maintenance needs:

   Average time allocated for ADL's - 2 - 3 hr/day
   Average time for Housekeeping - 1 - 2 hr/day

The maximum amount of care established for all levels of care were not established with regard to the need for supervision as a personal/respite care task. A recipient in any level of care may require 24-hour-a-day supervision due to confusion, disorientation, wandering or aggressive behavior, or inability due to physical condition and social support to remain safely alone (see Chapter IV, "Covered Services"). DMAS will not reimburse for 24-hour-per-day care through personal care, as this level of in-home service cannot be shown as a cost-effective alternative to nursing facility care. Additional time can be added to the Plan of Care beyond the maximum amount of time for that recipient's level of care, as long as the amount of supervision needed does not exceed the eight hours per day which is the maximum amount of supervision that can be added to the Plan of Care. If the individual requires more supervision than can be provided through the time allowed for ADL, housekeeping and supervision through personal care, the recipient must have a support system that is able and willing to provide those additional supervision needs. The provider must contact DMAS with written documentation of the need for the supervision and the plan for the recipient's care during times when the aide will not be in the home. Prior authorization for the increase must be obtained from DMAS.

It is important to recognize that the guidelines provided reflect the way in which DMAS will review plans of care for individual recipients based on a general profile of recipients which will typically fall within these levels of care. However, since the level of care does not reflect the medical needs of the recipient as per his or her diagnosis and recent history nor does it reflect the idiosyncrasies of that recipient's personality or environment, the guidelines cannot fully capture the range of needs and support which the provider may encounter. For instance, housekeeping needs will vary according to the abilities of the recipient as reflected in the level of care and according to the amount of social support received from either a live-in caregiver or some other family/community support. Other factors, such as the presence of on-site laundry facilities, the lack of modern plumbing, heating and cooking facilities, will also determine the amount of time required for housekeeping.

The provider is expected to use his or her professional judgement to determine the amount of service needed by the recipient. As long as the amount is within the maximum established for that level of care and the decision process can be documented and appears logical, DMAS will not deny reimbursement for services. DMAS will receive reports which will summarize recipient utilization and levels of care for providers and geographical localities. Analysts will review these reports for any exceptions to patterns of normal utilization.

Plan of Care for AIDS Waiver Individuals

Development of the Plan of Care for an individual under the AIDS Waiver must be completed in the same manner as outlined above. Because of the fluctuating condition of most AIDS Waiver recipients, often, the individual under the AIDS Waiver will not meet the level of care every day on an ongoing basis. The agency must instruct the aide providing personal care to communicate promptly any change in the recipient's ability to perform self-care.

If services are temporarily suspended (e.g., the aide doesn't go for a week because the recipient is feeling better and is able to do all self-care), the agency should instruct the recipient to contact it as soon as there is again a need for the service. The agency is not expected to change the Plan of Care every time the recipient's condition changes, unless the change is expected to continue to last at least 30 days, as long as the agency and recipient are communicating and services are not offered when not needed. Supervision is appropriate as needed (e.g., for monitoring of the recipient's condition due to medications the recipient receives) as long as the need is clearly stated and the aide is not used as a general companion for the recipient who has no mental or physical need for the presence of the aide and as long as the recipient has no one else available to provide that supervision.

If services remain suspended for more than 30 days, the RN must notify DSS and the case manager via the DMAS-122. The recipient should be instructed to contact the case manager to reinstate personal care services, or if there is no case manager, the recipient should be instructed to contact the Pre-Admission Screening Committee.

RESPONSIBILITIES OF THE PROVIDER FOR MONITORING OF RECIPIENT SERVICES

The provider agency is responsible for monitoring the ongoing provision of services to each Medicaid recipient. This monitoring includes:

- The quality of care provided by the aide;
- The functional and medical needs of the individual and any modification necessary to the Plan of Care due to a change in these needs; and
- The individual's need for support in addition to care provided by personal/respite care. This includes an overall assessment of the individual's safety and welfare in the home with personal/respite care.

RN Responsibilities

1. 30-Day Supervisory Visits: The Nurse is responsible for conducting supervisory visits to the recipient's home at least every 30 days, for providing any necessary supervision to the aide and recipient and recording all significant contacts in the recipient's file. During visits to the recipient's home, the nurse must observe,

evaluate, and document the adequacy and appropriateness of personal/respite care services with regard to the recipient's current functioning status, and medical and social needs. The aide's record must be reviewed, and the recipient's (or family's) satisfaction with the type and amount of service must be discussed.

The nurse's documentation of this supervisory visit may be in the form of a soap note or the nurse may use a standardized form to record the 30-day supervisory visit. Appendix C contains an example of a standardized form. The Recipient Progress Report submitted to DMAS annually may take the place of the RN 30-day summary note for the month the progress report form is completed. Regardless of the format used, the RN summary must note:

- Any change in the previously documented recipient's medical condition, functioning status and social support. The RN supervisor is expected to know the nursing facility and pre-nursing facility criteria in Appendix D and to apply these criteria in the assessment of whether the recipient continues to meet the criteria to receive personal/respite care services. In the event that the RN supervisor determines that the recipient does not meet the criteria for personal/respite care services, then the RN supervisor must terminate services as per the instructions in Chapter V;

- Whether the Plan of Care is adequate to meet the recipient's needs or if changes need to be made;

- Dates of any lapse of services and why (hospitalization admission and discharge dates, aide not available, etc.).

- The presence or absence of the aide in the home during the visit; and

- Any other services received by the recipient (the nurse does not need to note each month the ongoing receipt of a service but must note any change to a service previously noted).

In addition to the routine information which must be documented in the nurse's 30-day summary, there are several areas which require special monthly documentation by the nurse. Each of these areas is described in "Covered Services" earlier in this Chapter:

Supervision - The addition of supervision to a recipient's Plan of Care must be pre-authorized by either the pre-admission screening entity or DMAS if addition of supervision to the Plan of Care will result in the total hours exceeding the number of hours allowed within the recipient's level of care (also described in Chapter IV). DMAS requires that the nursing supervisor document on the Request for Supervision form the amount of supervision needed, the reason for the need for supervision, and that all other support persons' ability to provide supervision has been explored and submit this form to DMAS, along with a revised Plan of Care, for authorization. A copy of the analyst's approval must be maintained in the file.

Bowel and Bladder Program - A written physician's order in the recipient's file must specify the method and type of digital stimulation and frequency of administration. The nurse supervisor must document that the aide has received special training in bowel and bladder program management, has knowledge of the circumstances that require immediate reporting to the nurse supervisor, and the nurse supervisor has observed the aide performing this function. The aide's continuing understanding and ability to perform bowel and/or bladder programs must also be documented in the 30-day nursing note.

Range of Motion Exercises - The written physician order which indicates the need and extent of range of motion exercises which are to be performed must be in the recipient's file. The nurse supervisor must document in the recipient record that the aide has been instructed by the nurse supervisor in the administration of maintenance range of motion exercises and that the aide's correct performance of these exercises has been witnessed and documented by the nurse supervisor. The continued need for range of motion exercises and the monitoring of the aide's performance of these exercises must be noted in the 30-day nursing note.

Routine Wound Care - Each month the nurse supervisor must document the status of the wound and the monitoring of the aide's care.

Catheter Care - When routine care of an external condom catheter is to be provided by the personal care aide, the RN supervisor must indicate in the initial RN supervisory note that the aide is providing condom care and what instructions the aide has received from the supervisor regarding this care. The initial application of the condom catheter must be observed by the RN supervisor and documentation must indicate the aide's ability to perform this procedure. The same procedure must be followed when substitute aides are providing condom catheter care.

2. Six Month Reassessments: Once every six months, the RN must provide a full assessment of the recipient's current medical, functional and social support status and a complete summary of all services received. The six-month reassessment may coincide with the DMAS request for the Recipient Progress Report, but must be completed once every six months regardless of whether the Recipient Progress Report is due. Documentation of the six-month reassessment must include a complete review of the recipient's needs and available supports and a review of the Plan of Care.

3. Routine Monitoring: The RN supervisor must review the Aide Records submitted weekly by the aide to determine whether the aide is recording appropriately and whether any change in the recipient's condition has occurred which would warrant additional intervention by the RN. Any concerns related by the recipient, family/primary caregiver, aide or other involved professional must be noted and followed-up on by the RN. Any time the permanently assigned aide changes, the RN must introduce the aide to the recipient and the recipient's Plan

of Care. The RN supervisor is responsible for taking appropriate action to assure continued appropriate and adequate service to all recipients. Appropriate actions may include: counseling an aide about the care to be provided to the recipient, requesting from DMAS an increase to the recipient's Plan of Care to include supervision, discussing with the recipient's family the need for additional care for the recipient or contacting DMAS to request a special review of the recipient's case. Any time the agency is unsure of the action which needs to be taken, the agency should contact DMAS utilization review staff assigned to the agency for consultation.

Aide Responsibilities

The aide is responsible for following the Plan of Care, notifying the RN supervisor of any change in condition or support or problem that arises and documenting the performance of duties on the Aide Record. The aide must document on the Aide Record the specific services delivered to the recipient and the recipient's response. This record must also contain the arrival and departure time of the aide for personal/respite care services only. The aide must record comments or observations about the recipient on a weekly basis. Aide comments should include observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to services rendered. The Aide Record must be signed by the aide and the recipient once each week to verify that personal care services have been rendered. **Signature, times and dates must not be placed on the DMAS-90 prior to the last day of the week that the services are delivered.**

Any corrections needed to the aide log should be made by drawing a line through the incorrect entry and reentering the correct information. **White-out must never be used for correction.** Copies of all Aide Records are subject to review by State and federal Medicaid representatives. The records contained in the chart must be current within two weeks at all times.

If the recipient is unable to sign the Aide Record, a family member or friend may sign. If no other person is able to sign the Aide Record, the recipient may make an "X." If the recipient is unable to sign or make an "X," a notation must be made in the front of each recipient record that "recipient is unable to sign."

The Aide Record must be completed on a daily basis, neither before nor after the date of service delivery. The DMAS-90 is designed to contain one calendar week of service provision and should be utilized in this manner. It is the responsibility of the provider agency to assure that the Aide Records are delivered to the agency and filed in the recipient's record.

Prior to filing the Aide Record in the recipient's file, the Aide Record must be reviewed and the RN supervisor's signature affixed to the lower right hand corner. Periodic review of the aide's record will ensure that the RN supervisor is aware of any change in the recipient's needs documented by the aide or any change in the Plan of Care which may be

indicated by the aide's charting. **An accurately signed and dated Aide Record is the only authorized documentation of services provided for which DMAS will reimburse.**

See Chapter VI, Section entitled "Requests for Billing Materials and All Forms Used by Provider Agencies," regarding the ordering of forms.

Health and Safety Issues

When the agency becomes aware that the services being provided and the recipient's current support system may not adequately provide for the recipient's safety, the agency should immediately contact the DMAS utilization review analyst to discuss the case specifics. The intent of this discussion is to determine whether the recipient's current status represents a potential risk or an actual threat to his or her safety, health and welfare.

A potential risk is identified as a deterioration in either the recipient's condition and/or environment which, in the absence of additional support, could result in harm or injury to the recipient.

An actual threat is the presence of a harm or injury to the recipient which can be attributed to the recipient's deterioration and lack of adequate support (e.g., the recipient becomes anemic, malnourished, dehydrated due to the inability to obtain food and water; the recipient develops decubitus due to lying in urine or feces, etc.).

To determine whether an actual threat may exist, the agency should consider the following:

1. Is the recipient capable of calling for help when needed?
2. Is there a support system available for the recipient to call?
3. Can conditions be arranged for the recipient to care for basic needs when the support system is absent?
4. Is the recipient medically at risk when left alone (i.e., is the recipient falling frequently)?
5. Has some harm or injury to the patient been reported?
6. Does the recipient express fear or concern for his or her welfare?

If answers to the above indicate a potential risk, the agency should still advise the utilization review analyst of the situation, and the analyst can determine whether a special home visit is indicated.

When a real threat to the recipient's health, safety and welfare exists, the analyst will attempt to assess whether additional services can be obtained to maintain the recipient in a home environment. If continued maintenance in the home is not possible, the analyst will instruct the provider agency to initiate procedures to terminate services and advise

the recipient and family/primary caregiver that nursing facility services should be considered. See Chapter V for the procedures to transfer a recipient from personal care to nursing facility services.

Changes to the Plan of Care

The provider is responsible for making modifications to the Plan of Care as needed to assure that the aide and recipient/family are aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the recipient. The provider is able to establish the amount of service in the Plan of Care which is appropriate to meet the recipient's needs as long as the maximum number of hours per week for that recipient's level of care is not exceeded and the increase in service level is not a result of adding supervision to the Plan of Care. **Under no circumstances can the recipient receive more hours of care than his or her level of care allows, unless authorization has been given by DMAS and recorded in the recipient's file.**

Any time the number of hours for a recipient needs to be changed, a new provider agency Plan of Care must be developed and a copy sent to the DMAS analyst assigned to the agency to ensure the correct amount of hours is entered into the system to allow for correct claims processing. The most recent Plan of Care must always be in the recipient's home. The provider does not need to change the Plan of Care to capture minor changes in tasks within categories or days of the week tasks are to be performed as long as the number of hours does not change.

The addition of supervision to the Plan of Care must be pre-approved by the DMAS utilization review analyst according to the same procedures used to request an increase due to a change in the recipient's level of care.

Addition of Supervision/Increase Beyond the Recipient's Level of Care

The provider agency must follow these procedures to request an authorization whenever a change in the recipient's condition (physical, mental, or social) indicates that either:

- The recipient requires supervision to be added to the Plan of Care;
- The recipient's needs have changed creating a change in the recipient's level of care, and the number of hours now needed exceed the number the individual was receiving in the former level of care category; or
- An increase to the Plan of Care is needed for more than the amount allowed according to the recipient's current level of care.

The provider agency must complete a DMAS-97A and provide justification to validate the need for and use of hours prior to requesting the increase. The provider must mail the completed DMAS-97A and any additional justification (a Supervision Request form must be submitted if supervision is the reason for the increase to the Plan of Care) to his or her assigned analyst. Once this information is received, the analyst will contact the provider agency and either request additional information or grant or deny the request.

The decision and authorization for, or denial of, increased hours can be transmitted by telephone, and the provider agency must note this decision in the recipient's record. However, written confirmation should be received ~~from~~ by DMAS within 10 working days.

DMAS will send a letter to the recipient confirming approval of the increase in hours and providing the recipient the right to appeal the decision. DMAS will send a copy of this letter confirming approval of the increase to the provider agency to be filed in the recipient's record.

If DMAS does not approve the request to increase the hours (whether the increase is requested by the recipient or on the recipient's behalf by the personal care provider agency), the letter to the recipient must indicate the reason the change was not made. This letter must also give the recipient notification of his or her right to appeal this decision. DMAS will send a copy of this letter to the provider agency.

PROVIDER'S RESPONSIBILITY FOR THE PATIENT INFORMATION FORM (DMAS-122)

The Patient Information form (DMAS-122) is used by the provider and the local Department of Social Services to exchange information regarding the responsibility of a Medicaid-eligible recipient to make payment toward the cost of services or other information that may affect the eligibility status of a recipient. (Appendix C contains a sample of the form and the instructions for its completion.) The provider is responsible for ensuring that a current completed DMAS-122 is in the recipient's record. A new DMAS-122 is generated by the local Department of Social Services at least annually. Uses of the DMAS-122 include the following.

Personal/Respite Care Service Initiation

As soon as the provider agency initiates services, it must send a Patient Information form (DMAS-122) to the eligibility unit of the appropriate local Department of Social Services indicating **the agency's first date of service delivery**. For AIDS/HIV+ and symptomatic waiver services, the provider should notify the case manager of the first day of service delivery. If there is no case manager, the provider should follow normal procedures.

It is advisable for the provider to contact the eligibility worker prior to the start of services for assurance of the recipient's Medicaid eligibility. After being notified of the begin date of service, the eligibility worker will return the same DMAS-122 to the provider with the bottom section completed, showing confirmation of the recipient's Medicaid identification number, the recipient's income, and the date on which the recipient's Medicaid eligibility was effective. A copy of this completed DMAS-122 must be maintained in the recipient's file.

Patient Pay Amount

Each Medicaid recipient of home and community-based care is allowed to keep a portion of his or her income to meet his or her own maintenance needs. This maintenance allowance is higher for the individual staying at home in community-based care than for

the individual in a nursing facility. The maintenance allowance for recipients of waiver services is equal to 300% of the current Supplemental Security Income (SSI) individual payment standard.

The maintenance allowance and any other allowable deduction (e.g., medical insurance payments) are deducted from the individual's income to arrive at that individual's patient pay amount. AIDS/HIV+ and Symptomatic Waiver recipients will usually not have a patient pay amount. The patient pay for home and community-based care from a SSI recipient will always be $0.

Additional Uses of the DMAS-122

It is the responsibility of the provider to notify his or her assigned analyst at DMAS and the Department of Social Services (or the case manager for AIDS/ARC Waiver services) via the DMAS-122 of **the agency's last date of service delivery** when any other of the following circumstances occur:

- The agency's services are stopped because the recipient dies, is discharged (including transfer), or coverage terminated; or
- Any other circumstances (including hospitalization, except as outlined in Chapter V) which cause services to cease or become interrupted for more than 30 days.

EXAMPLE: The agency delivered services to a recipient through the third of a given month, then the recipient was hospitalized and died on the fifteenth. Even though the agency kept the case open to see if the recipient would need services post-hospitalization, the date submitted on the DMAS-122 would be the third since this was the agency's **last date of service delivery.**

It is the responsibility of the provider to assure that a DMAS-122 for the current year is in the record. For AIDS Waiver recipients, if there is no patient pay amount and the recipient has a case manager, only the case manager is required to have a copy of the DMAS-122 in the recipient's file.

PERSONAL CARE AGENCY DESK REVIEWS/RECIPIENT PROGRESS REPORT

Federal regulations require that each individual authorized for waiver services be evaluated on an annual basis to assure that the individual continues to meet the criteria for the waiver and that the services offered through the waiver are appropriate and adequate to meet the needs of the individual. DMAS meets this requirement through conducting home visit assessments for individuals reviewed during agency on-sites and through review of documentation submitted by the agency annually on everyone who was not reviewed during that year. This desk review evaluation is scheduled six months from the date that the analyst was on-site at the agency. Desk reviews and the Recipient Progress Report are not required for respite care recipients.

DMAS will send the provider a letter which requests that the provider complete a Recipient Progress Report for every recipient who was not reviewed by the analyst during the on-site visit and who is still receiving services from the agency. The provider RN is responsible for completely describing the recipient's functional status, medical/nursing needs and the appropriateness of the Plan of Care. The functional status assessment should be completed using the DMAS definitions found in Appendix D. These definitions are the same as those used by DMAS and the Pre-Admission Screening Committee to determine whether the individual meets the functional status component of the nursing facility criteria. The completion of this form substitutes for the required 30-day nurse supervisory note during the month in which the Recipient Progress Report is submitted. A copy of this form is found in Appendix C.

The Recipient Progress Report should be sent to the DMAS utilization review analyst responsible for that provider's review activity. For AIDS Waiver recipients, the Recipient Progress Report should be sent to the individual's case manager. If the recipient does not have a case manager, forward the Recipient Progress Report to the assigned analyst. The analyst will review the materials submitted and contact the provider if any problems are identified. **The provider will not be reimbursed for services rendered to any recipient for whom the documentation is not received within the month due.**

AUTHORIZATION OF PERSONAL CARE AND RESPITE CARE TO THE SAME RECIPIENT

Personal care services are defined as long-term maintenance or supportive services which are necessary to enable the individual to remain at home rather than enter a nursing facility. Although the recipient of services must meet the same long-term care criteria for personal care as respite care, the need for personal care services must be continuous whereas the need for respite care is periodic.

Also, respite care can only be authorized when there is a primary caregiver living in the home with the elderly or disabled individual, whereas personal care can be offered to individuals living alone. Authorization of respite care as a routine relief to the caregiver should only be given when no other services are being received by the elderly or disabled individual which might provide a respite period for the caregiver. Respite care could only be offered to caregivers as an adjunct to another primary home and community-based care service under the following conditions:

- The individual has been authorized to receive a primary home and community-based care service by the Nursing Home Pre-Admission Screening Committee, and such care has been initiated; or

- The primary home and community-based care services offered to the individual are determined to be insufficient to prevent the breakdown of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the dependent individual.

Personal care, when offered in conjunction with episodic respite care service, would be considered the primary home and community-based care service necessary for the individual's continued maintenance in the community. Respite care services offered as a sole home and community-based care service can be authorized by the Pre-Admission Screening Committee. However, when offered in conjunction with another home and community-based care service, respite care services must be pre-authorized by DMAS. **The personal care provider must contact the Department of Medical Assistance Services utilization review staff when the need for episodic respite care as a secondary home and community-based care service has been identified according to the criteria above. DMAS will conduct an assessment of the individual caregiver's need for respite care, and if appropriate, authorize respite care.**